

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11503

CERTIFICATE OF DEATH

11508

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN lb <b>10 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MARY ALBERTA BLACKISTONE</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1905</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM GOUGH</b>		14. MOTHER'S MAIDEN NAME <b>SADIE HAYDEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>LUCIOUS BLACKISTONE LEONARDTOWN, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> 464 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Telro melio phlebitis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 20, 1967</b> , to <b>Aug 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 25, 1967</b> , and that death occurred at <b>10P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W.D. Boyd</b>		22b. DATE SIGNED <b>8/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Aug. 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>8 HOLLYWOOD, MARYLAND</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1955

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*William H. Hall*  
*St. Louis, Mo.*

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
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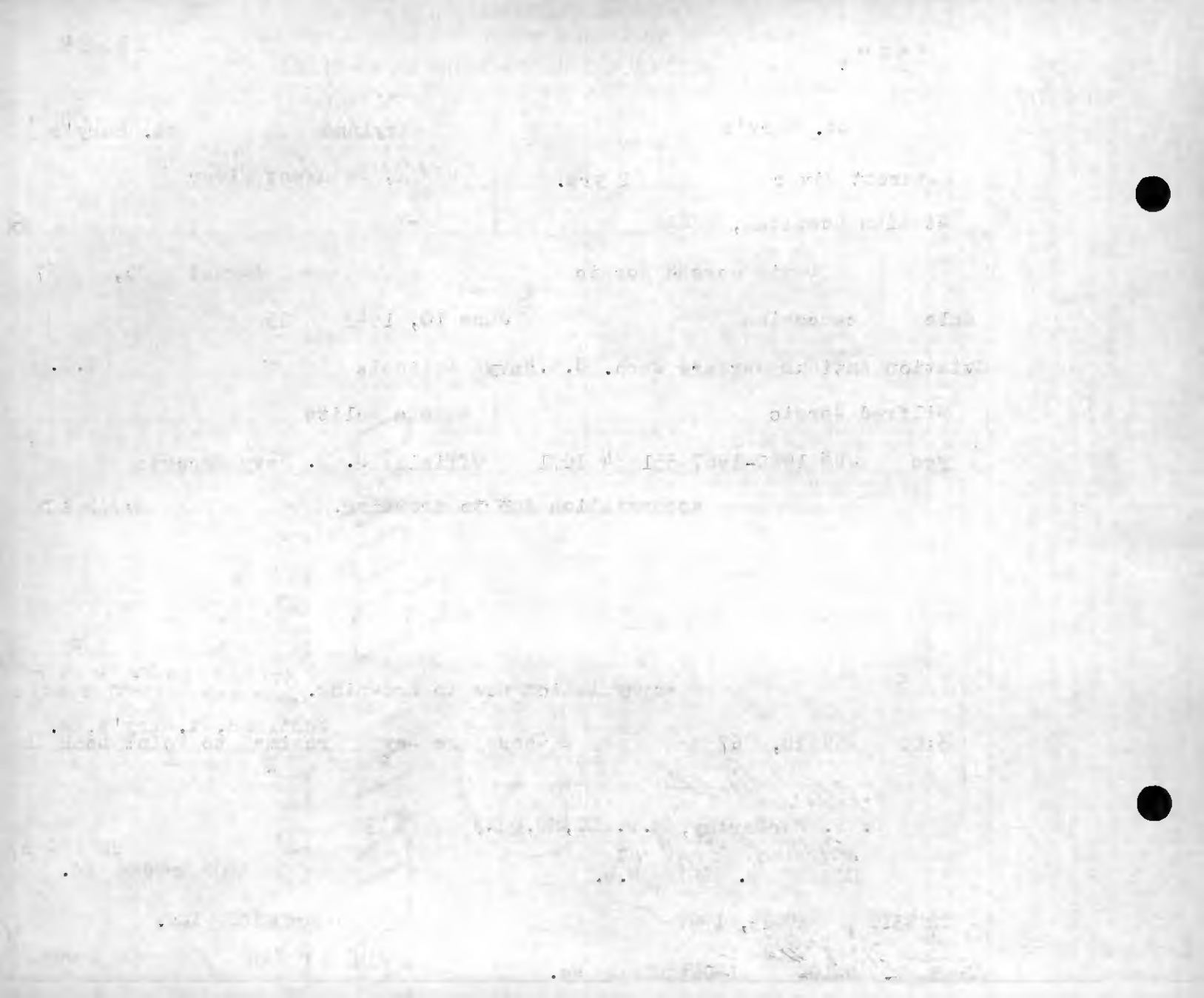
FOR STATE HEALTH OFFICIAL

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11504

11509

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (If deceased lived, (if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>	
c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		d. STREET ADDRESS <b>RR-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Station Hospital, USNAS</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David Joseph Borgic</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1942</b>
9. AGE (In years lost birthday) <b>25</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aviation AntiSub Warfare Tech. U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Wilfred Borgic</b>		14. MOTHER'S MAIDEN NAME <b>Waneta Bolite</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes JUN 1960-1967</b>		16. SOCIAL SECURITY NO. <b>351 34 1071</b>	
17. INFORMANT <b>Official U. S. Navy Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to drowning.</b> DUE TO (b) <b>929.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Asphyxiation due to drowning. ATTEMPTED TO SWIM TROY DISABLED BOAT TO SHORE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3:00</b> p.m. <b>AUG 28, 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b>		20f. (City or town) (County) (State) <b>Scotland, St. Mary's, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>28 AUG 67</b>	
ACTUAL SIGNATURE <b>C. F. MacCarthy, M.D. (LT, MC, USN)</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT</b>		23b. DATE THEREOF <b>AUG 29, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>JOHN M. WILCH</b>		23d. LOCATION (City or Town) (County) (State) <b>NOKOMIS ILL.</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

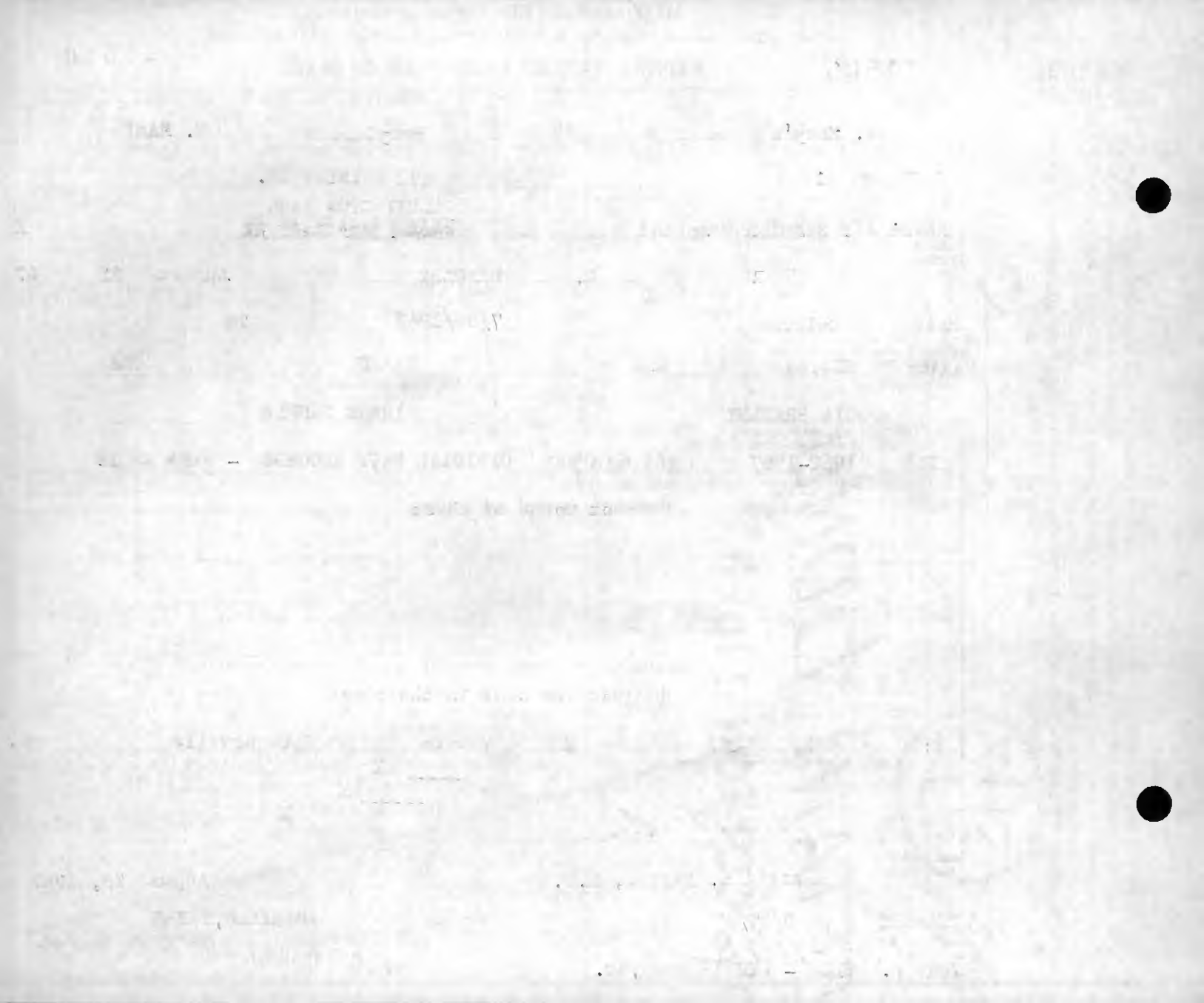
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11505

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11510

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>ST. MARYS</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PATUXENT RIVER</b>		c. LENGTH OF STAY IN 1b <b>172 CHINLEE DR.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Air Station Hospital</b>		d. STREET ADDRESS <b>LEXINGTON PARK</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD R. BRADLEY</b>		4. DATE OF DEATH Month Day Year <b>August 25 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/1943</b>
9. AGE (In years lost birthday) <b>24</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARACHUTE RIGGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	
11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BOBBIE BRADLEY</b>		14. MOTHER'S MAIDEN NAME <b>IRENE SAMPLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1962-1967</b>		16. SOCIAL SECURITY NO. <b>464 68 0300</b>	
17. INFORMANT <b>OFFICIAL NAVY RECORDS - SAME AS 1B</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>981X</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subject was shot in the chest</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:50 8 25 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tavern</b>		20f. (City or town) (County) (State) <b>Hermansville Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		22. DATE SIGNED <b>August 25, 1967</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT</b>		23b. DATE THEREOF <b>8/27/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>		23d. LOCATION (City or Town) (County) (State) <b>AMARILLO, TEXAS</b>	
24. FUNERAL DIRECTOR <b>John M. Welch</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11511

11506

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL PINEY POINT</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL PINEY POINT</b>	
c. LENGTH OF STAY IN life <b>LIFE</b>		d. STREET ADDRESS <b>18.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARENCE A. BRISCOE</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 27, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 8, 1896</b>
9. AGE (In years lost birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BRISCOE</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE WILSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>570-01-4703</b>	
17. INFORMANT <b>DENICE M. DICKENS</b>		Address <b>2108-38TH. ST. S.E. WASH. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W.D. Boyd M.D.</b>		22. DATE SIGNED <b>8-29-67</b>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>AUG. 31, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>VALLEY LEE, ST. MARY'S, MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

$$\text{C}_2\text{H}_5\text{Br} + \text{NaOH} \rightarrow \text{C}_2\text{H}_5\text{OH} + \text{NaBr}$$

WATSON, JAMES • 13 • 1001 E. 18th

U.S. DEPARTMENT OF THE INTERIOR

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CONFIDENTIAL - SECURITY INFORMATION

TABLE 1. *Summary of the 1999-2000 season for the 1000-hour rule. The number of hours of training for each of the 1000-hour rule participants is shown in the first column. The number of hours of training for each of the 1000-hour rule participants is shown in the first column. The number of hours of training for each of the 1000-hour rule participants is shown in the first column.*



# FOR STATE HEALTH DEPT.

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VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

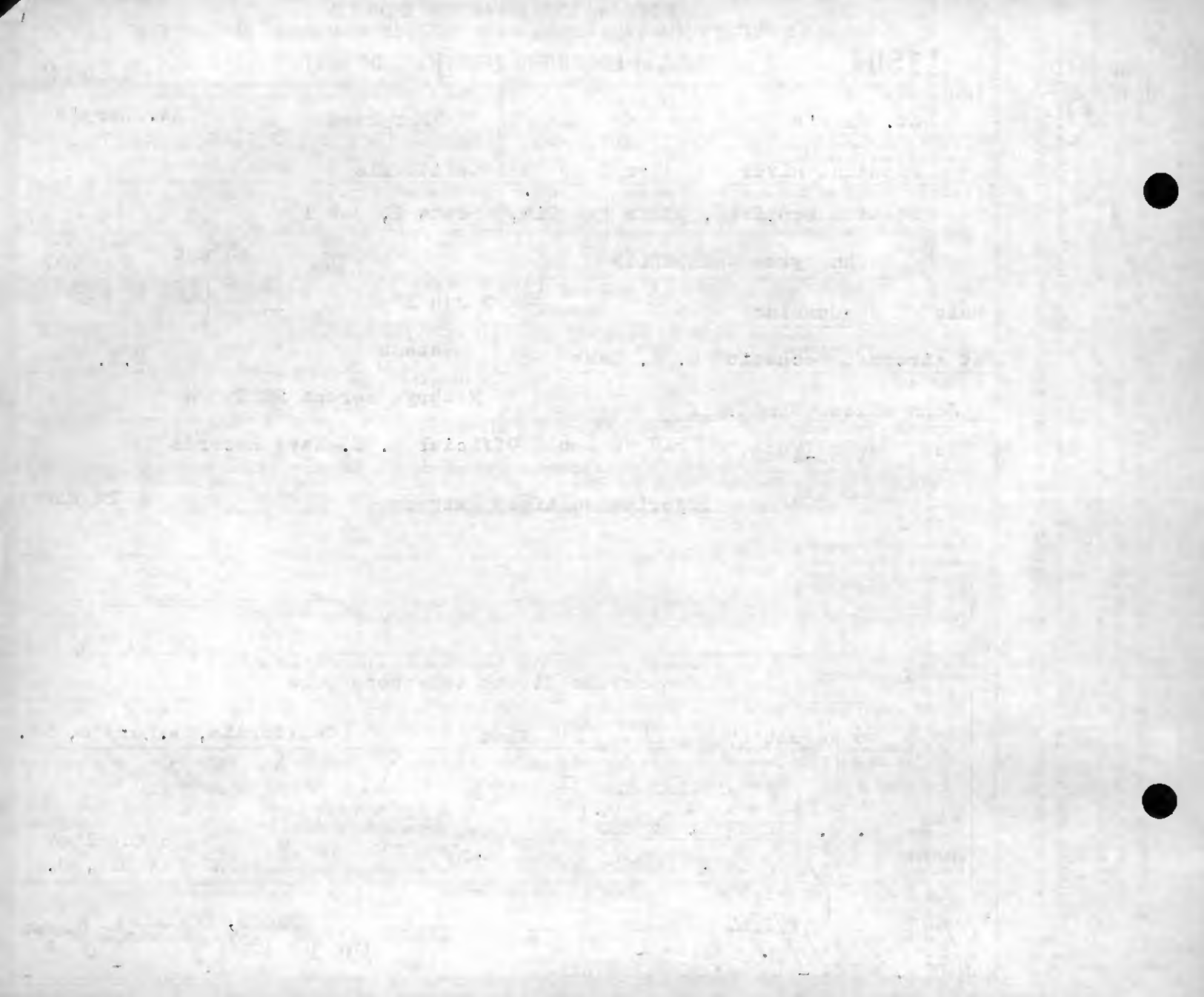
11507

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11512

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>2yr 3 mo</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Station Hospital, USNAS Pax Riv,</b>		d. STREET ADDRESS <b>Route 2, Box 194</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Byron</b> Last <b>CHAMBERLIN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Jan 1938</b>
9. AGE (In years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jet Aircraft Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>Montana</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John Allen CHAMBERLIN</b>	
14. MOTHER'S MAIDEN NAME <b>Kathryn Bertha PETERSON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 1955-1967	
16. SOCIAL SECURITY NO. <b>517 40 1262</b>		17. INFORMANT Address <b>Official U. S. Navy Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries Multiple Extreme</b> DUE TO <b>8214</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>20 Minute</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Motorcycle Struck telephone pole</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>0750</b> a.m. <b>6</b> p.m. <b>August 19 67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> or work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>	20f. (City or town) (County) (State) <b>California, St. Mary's, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>G. J. VUKMER Lt MC USN</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>J. J. Chamberlin</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>6 Aug 1967</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>NAS PAX RIV, MD.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT</b>	
23b. DATE THEREOF <b>8/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HELENA, MONTANA</b>	
23d. LOCATION (City or Town) (County) (State) <b>HELENA, MONTANA</b>		23e. REC'D BY REGISTRAR <b>John M. Welch</b>	
23f. DATE <b>AUG 10 1967</b>		23g. REGISTRAR'S SIGNATURE <b>John M. Welch</b>	

JOHN M. WELCH - LEONARDTOWN, MARYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #9 Film #G392 9/11/67					11513						
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>					d. STREET ADDRESS <b>5 Lincoln Avenue</b>						
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>Courtney</b>					4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1967</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 21 1967</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James (Unknown) Smith</b>					14. MOTHER'S MAIDEN NAME <b>Mary Frances Courtney</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mother</b>		Address <b>Lexington Park, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, or bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>8/21</b> , 19 <b>67</b> to <b>8/21</b> , 19 <b>67</b> that (I) <del>(we)</del> last saw the deceased alive on <b>8/21</b> , 19 <b>67</b> , and that death occurred at <b>5:00</b> PM, from the causes and on the date stated above.										22b. DATE SIGNED <b>8/22/67</b>	
22a. SIGNATURE <b>James P. Jarboe M.D.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>Great Mills, Maryland</b>				
22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe M.D.</b>					23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>8/23/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPHS CEMETERY</b>					23d. LOCATION (City, town or county) (State) <b>MORGANZA, MD.</b>						
24. FUNERAL DIRECTOR <b>Robinson's</b> <b>JOHN M. WELCH</b>					25a. REC'D BY REGISTRAR <b>August 25 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Charles J. Jager</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

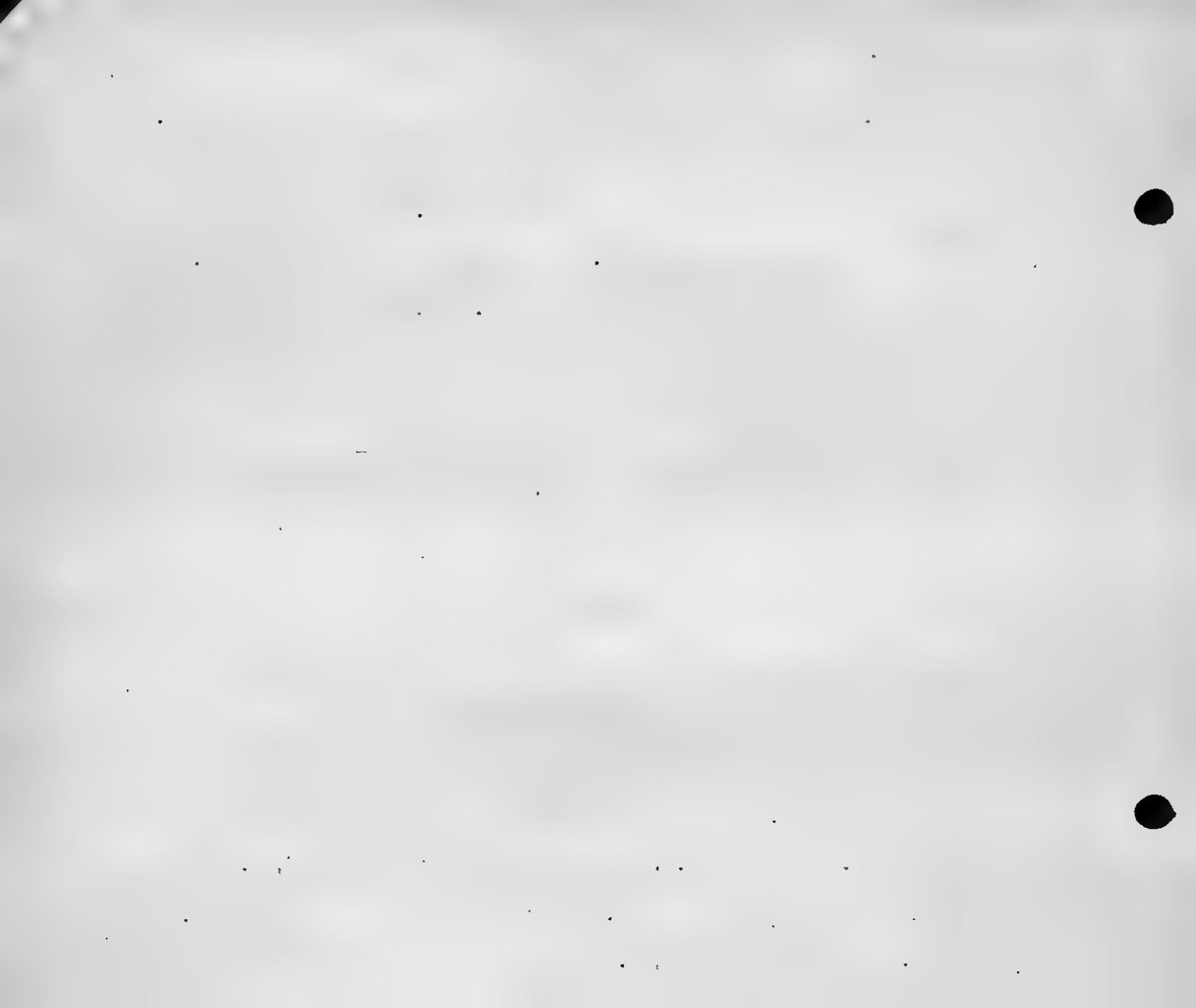
11509

11514

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ST. MARYS</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL MECHANICSVILLE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL MECHANICSVILLE</b> d. STREET ADDRESS <b>RT. #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>GEORGE</b> Middle <b>M.</b> Last <b>FENWICK</b>				<b>4. DATE OF DEATH</b> Month <b>AUG.</b> Day <b>9</b> Year <b>1967</b>					
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>NEGRO</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>AUG. 13, 1916</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>HARRY FENWICK</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>DELIA BUTLER</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WWII</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>HARRY FENWICK - SAME AS #2</b>		Address _____	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hemon tage, esophageal varices</i> DUE TO (b) <i>Cerebrosis of liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr 3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Jan 1, 1960</i> <b>to</b> <i>Aug 9, 1967</i> <b>that (II) (we) last saw the deceased alive on</b> <i>April 21, 1967</i> <b>and that death occurred at</b> <i>6 PM</i> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>J. Roy Guither</i>					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>8/11/67</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. ROY GUITHER M.D.</b>					<b>22d. ADDRESS</b> <b>MECHANICSVILLE, MD.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>8/12/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. JOSEPHS CEMETERY</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>MORGANZA, MD.</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John M. Welch</i>					<b>25a. REC'D BY REGISTRAR</b> <i>J. Charles Judge</i> <b>DATE</b> <b>AUG 14 1967</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
GM 1/64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

115.0

11515

1 PLACE OF DEATH a COUNTY <b>ST. MARYS</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>LEONARDTOWN</b>	c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>		d STREET ADDRESS <b>10107 PORTLAND PL.</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>KARL WILHELM (WILLIAM) HEINZMAN</b>		4 DATE OF DEATH <b>AUG. 10 1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8/6/1890</b>
9 AGE (In years lost birthday) <b>77</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11 BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>KARL WILHELM HEINZMAN, SR.</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIA HAUG</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>578-09-1115</b>	
17 INFORMANT <b>MRS. LOUISE HEINZMAN SAME AS #2</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Arteriosclerosis HD</b> DUE TO (c) <b>Syn</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm D Boyd</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WM. D. BOYD M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>LEONARDTOWN, MARYLAND</b>	
23a BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>8/14/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>	23d LOCATION (City or town) (County) (State) <b>Prince Georges Co. Md.</b>
23e FUNERAL DIRECTOR <b>JOHN M. WELCH - LEONARDTOWN, MARYLAND</b>		23f REC'D BY REGISTRAR <b>AUG 14 1967</b>	
		23g REGISTRAR'S SIGNATURE <b>John M. Welch</b>	



CERTIFICATE OF DEATH

11516

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON PARK,</b>	
c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		d. STREET ADDRESS <b>Box 232</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>VERNETTE AGNES HOPEWELL</b>		4 DATE OF DEATH Month Day Year <b>AUGUST 26, 1967</b>	
5. SEX <b>FEMALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>AUGUST 27, 1926</b>
9. AGE (In years lost birthday) <b>40 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 49 31</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CALIFORNIA MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL KANE</b>		14. MOTHER'S MAIDEN NAME <b>LAURA BEALE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>JEROME R. HOPEWELL</b>		Address <b>SAME AS # 2 ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>crash landing of Nord</b> DUE TO (b) <b>continuous pressure of</b> DUE TO (c) <b>small mistm</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 49 31</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>3 fractured ribs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8:17</b> , 19 <b>67</b> , to <b>8:26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8:26</b> , 19 <b>67</b> , and that death occurred at <b>7:55</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <b>Michael Barbarich</b>		22b. DATE SIGNED <b>8:29.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MICHAEL BARBARICH M. D.</b>		22d. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>AUG. 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY FACE CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>GREAT MILLS, ST. MARY'S, MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11512

CERTIFICATE OF DEATH

11517

1. PLACE OF DEATH a. COUNTY <u>ST. MARY'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARY'S CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARY'S CITY</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>18...</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEANNETTE BROME HOWARD</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 27, 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 21, 1881</u>
9. AGE (in years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARY'S CITY, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BROME JAMES THOMAS BROME</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ELIZA EMALINE THOMAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. SPENCE HOWARD JR. SAME AS # 2 ABOVE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 12, 19 58</u> , to <u>Aug 27, 19 67</u> , that (I) (we) last saw the deceased alive on <u>Aug 27, 19 67</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Greenwell</u>		22b. DATE SIGNED <u>8/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES GREENWELL M. D.</u>		22d. ADDRESS <u>LEONARDTOWN, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>AUG. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TRINITY EPISCOPAL CEMETERY ST. MARY'S CITY, MARYLAND</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

11518

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11518

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>ARLINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL AVENUE</b>		c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>2804 - 8TH STREET SOUTH</b>	
3 NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>E</b> Last <b>KECKLER</b>		4 DATE OF DEATH Month <b>AUGUST</b> Day <b>17</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>OCTOBER 20, 1895</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) yrs. <b>71</b>
10. FATHER'S NAME <b>SIMON KECKLER</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. MOTHER'S MAIDEN NAME <b>SUSAN N. MOTE</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		15. SOCIAL SECURITY NO.	
16. INFORMANT <b>WILLIAM B. KECKLER</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201 Coronary Occlusion</b> DUE TO (b) <b>Coronary Atherosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>59 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>pm</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>P. J. BEAN</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>P. J. BEAN M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>AUG. 17, 1967</b>		Address (Street, city, town, or county) <b>Princeton, VA</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE THEREOF <b>AUG. 19, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGE, MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>AUG 21 1967</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



CERTIFICATE OF DEATH

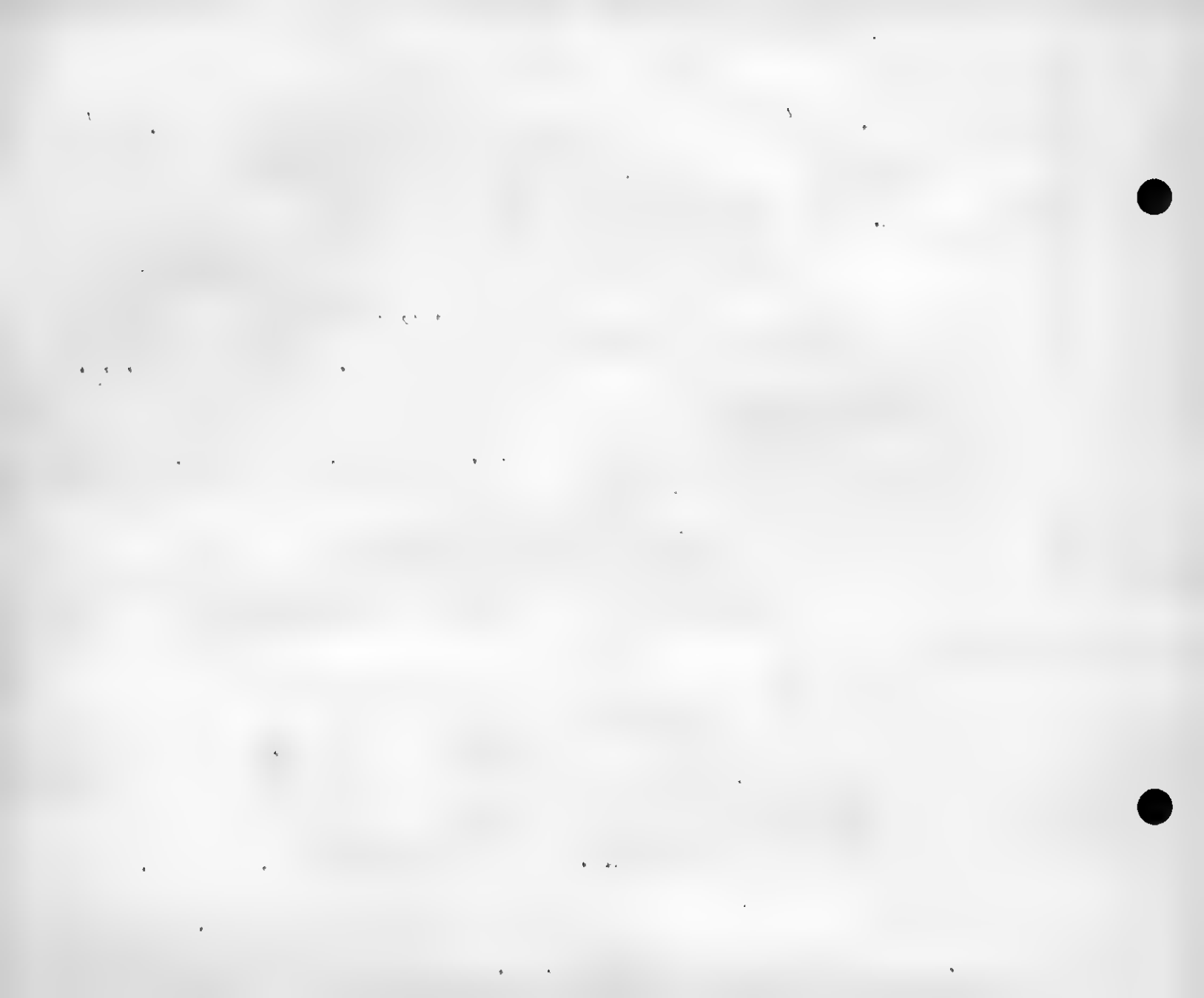
11514

11519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtoun</i>			c. LENGTH OF STAY IN Tb <i>17 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Drayden Rural</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Ambrose</i> Last <i>Lynn</i>				4. DATE OF DEATH Month <i>August</i> Day <i>5</i> Year <i>1967</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 21, 1894</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Charles Co., Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Stanton Warren Lynn</i>		14. MOTHER'S MAIDEN NAME <i>Alice Rebecca Turner</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-32-1345</i>		17. INFORMANT <i>Mrs. Dora Goode, Maddox, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4221</i> DUE TO <i>Cardiac Failure</i> (b) <i>Cardio-vascular disease</i> DUE TO <i>Cardio-vascular disease</i> (c) <i>Cardio-vascular disease</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11/15</i> , 19 <i>64</i> , to <i>8/5</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>8/5</i> , 19 <i>65</i> and that death occurred at <i>9:45</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Charles Greenwell</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Charles Greenwell, M.D.</i>				22d. ADDRESS <i>Leonardtoun, Maryland.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/7/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Maryland</i>	
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>				ADDRESS <i>Leonardtoun, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 9 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



CERTIFICATE OF DEATH

11515

11520

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c LENGTH OF STAY IN 1b <b>6 YEARS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 CHURCH STREET</b>		d. STREET ADDRESS <b>2 CHURCH STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>VERA</b> Middle <b>MAY</b> Last <b>PONT</b>		4 DATE OF DEATH Month <b>AUGUST</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JAN. 16, 1893</b>
9. AGE in years (last birthday) <b>74 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>WEST MAITLAND AUSTRALIA</b>		12 (IT ZEN OF WHAT COUNTRY?) <b>AUSTRALIA</b>	
13. FATHER'S NAME <b>ARTHUR WILLIAM DAUNT</b>		14. MOTHER'S MAIDEN NAME <b>LAURA JOHNSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JOYCE A. MATTINGLY</b>		Address <b>LEONARDTOWN, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.T.ON GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 19 1964</b> , to <b>Aug 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 14, 1967</b> , and that death occurred at <b>4:14 M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>John F. Fenwick M. D.</b>		22b. DATE SIGNED <b>8/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. FENWICK M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE THEREOF <b>AUG. 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND PRINCE GEORGE MD.</b>
24 FUNERAL DIRECTOR <b>W. CLARKE MATTINGLY LEONARDTOWN, MARYLAND</b>		25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11516 CERTIFICATE OF DEATH 11521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN b. <b>LEONARDTOWN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BROTHER AMADEUS C.F.X. (REUTER)</b>		4. DATE OF DEATH <b>AUG. 31 19 67</b>		5. SEX <b>MALE</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/21/1894</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>OHIO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE REUTER</b>		14. MOTHER'S MAIDEN NAME <b>ROSE BURBINK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218 54 5582</b>		17. INFORMANT <b>BROTHER SCOTT * SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>hypertensive cardiovascular disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>8/10/65</b> , 19....., to....., 19....., that (I) (we) last saw the deceased alive on <b>7/29/67</b> , and that death occurred at .. M., from the causes and on the date stated above.			
22a. SIGNATURE <b>S. Laurel, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>9/2/67</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>S. LAUREL M.D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/4/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART NOVITIATE</b>	
23d. LOCATION (City, town or county) (State) <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>John M. Welch</b>		25c. REGISTRAR'S SIGNATURE <b>John M. Welch</b>			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11517

11522

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ST. MARYS</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ST. MARYS HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARYS</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - GREAT MILLS</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>SARAH</u> <u>CATHERINE</u> <u>SANNER</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>AUG.</u> <u>24</u> <u>1967</u>	
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12/2/1889</u>	
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>DOMESTIC</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>WM. LEE BISCOE</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY P. BISCOE</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215 56 9870</u>	
<b>17. INFORMANT</b> <u>WM. SANNER - SAME AS #2</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>A. V. Heart Block</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June</u> <u>1962</u> <b>to</b> <u>Aug. 24</u> <u>1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Aug. 24</u> <u>1967</u> , <b>and that death occurred at</b> <u>4 P. M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>P. J. Bean</u>		<b>22b. DATE SIGNED</b> <u>8/26/67</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>P. J. BEAN M.D.</u>		<b>22d. ADDRESS</b> <u>GREAT MILLS, MARYLAND</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>8/27/67</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>TRINITY EPISCOPAL</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>ST. MARYS CITY, MARYLAND</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Welch</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 30 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>James J. [unclear]</u>		ADDRESS	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11518

## CERTIFICATE OF DEATH

11523

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>			c. LENGTH OF STAY IN IB <b>Newborn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Air Station Hospital</b>				d. STREET ADDRESS <b>603 Chinlee Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lisa Marie Schaefer</b>				4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 15, 1967</b>	
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.		IF UNDER 24 HRS. Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>St. Mary's Maryland</b>	
13. FATHER'S NAME <b>Edward Schaefer</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Mary Draper</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edward Schaefer</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO <b>Hemorrhagic diathesis of newborn</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity and hyaline disease</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>45 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>15 Aug</b> , 19 <b>67</b> , to <b>17 Aug</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>17 Aug</b> , 19 <b>67</b> , and that death occurred at <b>17 Aug</b> , 19 <b>67</b> , M, from causes and on the date stated above.							
22a. SIGNATURE <i>Jimmie R. Abel</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>17 Aug 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES R. ABEL</b>				22d. ADDRESS <b>Same as # 1</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/22/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR <i>John M. Welch</i>				25a. REC'D BY REGISTRAR <b>John M. Welch</b>		25b. REGISTRAR'S SIGNATURE <i>John M. Welch</i>	
26. FUNERAL HOME <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>				DATE <b>AUG 21 1967</b> <i>John M. Welch</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, not later than 24 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

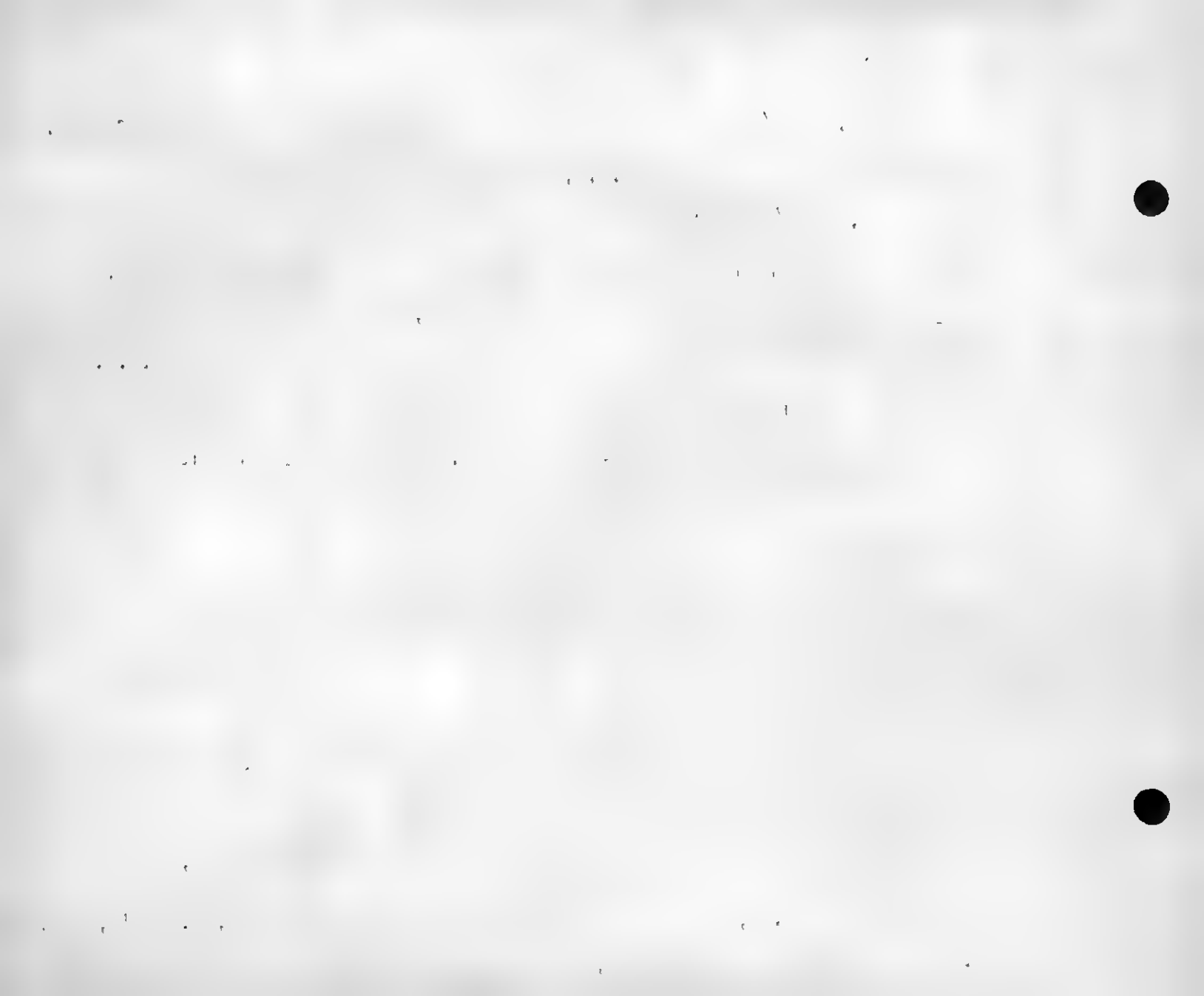
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11518

CERTIFICATE OF DEATH

11524

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u> ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>1 HOUR</u> MECHANICSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM MILTON SHORTER</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 27, 19 67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN, 14, 1901</u>
9. AGE (in years last birthday) yrs. <u>66</u>		10. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM HENRY SHORTER</u>	
14. MOTHER'S MAIDEN NAME <u>ELSIE JANE BROWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>214-58-0100</u>		17. INFORMANT Address <u>MARY C. JENNIFER MECHANICSVILLE, MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Aug</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Aug 27</u> , 19 <u>67</u> and that death occurred at <u>Aug</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leon W. Berber M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Leon W. Berber M.D.</u>		22d. ADDRESS <u>MECHANICSVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>AUG. 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>NEW MARKET, ST. MARY'S, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 31 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
SM 1/65

11520

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11525

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN ID <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				d. STREET ADDRESS <u>Avenue Rural</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Invin</u> Last <u>Tippett</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1917</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James O. Tippett</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Buckler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-6852</u>		17. INFORMANT <u>Mary Frances Tippett</u> Address <u>Avenue, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Infarction</u> 4201 DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W.D. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				22. DATE SIGNED <u>8/4/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bushwood, St. Mary's, Md.</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>				25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
ADDRESS <u>Leonardtown, Maryland</u>				DATE <u>AUG 7 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11521

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11526

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>				c. LENGTH OF STAY IN 1b <i>3 days</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i>				d. STREET ADDRESS <i>Rt. 2 Box 144A</i>			
3. NAME OF DECEASED (Type or print) First <i>Maggie</i> Middle <i>Stahl</i> Last <i>Zimmerman</i>				4. DATE OF DEATH Month <i>August</i> Day <i>13</i> Year <i>1967</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 8, 1909</i>	
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months <i>57</i> Days <i>13</i> Hours <i>18</i> Min. <i>1</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>John Fox</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Stahl</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)			
17. INFORMANT <i>Monroe Zimmerman</i>				Address <i>Rt. 2 Box 144A Leonardtown, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiovascular collapse</i> 1535 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal obstruction</i> DUE TO (c) <i>Carcinoma of the Colon</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <i>A. Samadi</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>A. SAMADI M. D.</i>				22d. ADDRESS <i>LEONARDTOWN, MARYLAND</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 16, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mennonite Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Loveville St. Mary's Md.</i>	
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i>				25a. REC'D BY REGISTRAR <i>AUG 18 1967</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

6. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

1. *Staphylococcus aureus*

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• FACTORS

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a copy of the original letter, and is signed by Abraham Lincoln.

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